19. d.: What actions has Aetna taken in the interest of policyholders to ensure the lowest negotiated prices from hospitals and out-patient facilities?

Aetna understands that health care has become unaffordable for many policyholders and that rising health care costs must be addressed We have made it clear to health care providers that continuing to cost shift to commercial payers is not an acceptable solution to the underlying cost issues they face. We are attempting to hold the line on cost increases in our provider negotiations and are prepared to allow contracts to terminate if necessary when agreement cannot be reached on reimbursement. During a negotiation, we may engage plan sponsors as needed to alert them to the issues in the negotiation. Aetna's medical personnel identify patients in active or planned course of care and assist in transitioning these patients to new health care providers when appropriate. These steps are time consuming and resource intensive but the process is necessary to effective management of cost and patient care. Once the termination occurs, we are prepared to leave a hospital, physician, physician group or other health care provider out of our network indefinitely, until a more acceptable contract can be negotiated.

Other Network Initiatives to Address Rising Cost

In addition to our negotiation and termination management processes, Aetna has developed or is in the process of developing network alternatives, new provider payment models, and benefit plans designed to improve the overall cost and quality of health care services rendered to our members. These are summarized below:

Narrow Networks – Aetna has implemented the Aetna Value Network (i.e. "narrow networks") in multiple California markets for HMO business. These networks are composed of a sub-set of Aetna's California HMO IPA network where the IPAs meet efficiency measures relating to the total cost of care.

Aexcel Networks – Aetna utilizes an episodic treatment grouping methodology to identify efficient providers in twelve surgical specialties. Quality screens are applied to the most efficient providers and these physicians are then made part of Aetna's Aexcel provider network. These networks can be coupled with benefit plans that encourage patients to use Aexcel providers.

Pay for Performance (P4P) – Aetna participates in the Integrated Healthcare Association's California P4P program. This program has demonstrated some improvement in quality, and is now proposed to include efficiency measures for payments in 2011. The efficiency metrics upon which the enhanced program is based are designed to lower overall cost. Aetna is also in the process of independently enhancing provider incentives based on site of service, re-admissions, and ER and inpatient utilization.

Bundled Payments – Aetna is working with the Integrated Healthcare Association in collaboration with other health plans and providers to develop and implement an all inclusive bundled payment mechanism for certain surgical procedures. While this program is currently limited to Aetna's HMO business, it will be expanded beyond the initial pilot phase if successful. Bundled payments are considered one potentially effective way of aligning the payment methodology with a patient outcome of higher quality and lower cost.

Institutes of Quality (IOQ)/Institutes of Excellence (IOE): Aetna has established organ transplant IOE's and a Bariatric Surgery IOQ network in California. We are piloting a Cardiac IOQ, an Infertility IOE and other IOQs and IOEs are under consideration, including orthopedics and oncology. These networks are developed using consistent scoring systems which include both quality and cost metrics. These networks are often paired with benefit plans that encourage or require members to utilize IOE's/IOQ's in order to receive maximum benefits under the plan.

Clinically Integrated PPO Networks - Aetna is working on a pilot with a large IPA in Southern California that is interested in moving to a clinically integrated model for their PPO business. This IPA and many other California IPAs have developed sophisticated methods of managing their HMO patients that both improve quality and lower cost. Examples include primary care physician management of patient care, use of claims and other data to identify and manage patients with chronic illness, referral management focusing on appropriateness of referral and effective care management, including hospitalist teams. The primary barrier to applying these techniques to a PPO population is the misalignment of payment incentives under fee-for-service reimbursement. Fee for service reimbursement, unlike capitation -- the prevalent payment methodology for the HMO -- creates incentives for physicians to maximize revenue by doing more, not necessarily what results in better patient care. Aetna will pay a care management fee and is establishing performance benchmarks and performance targets which if met would be expected to result in lower cost and improved quality. Aetna is willing to share in any cost savings, permitting the group to use this additional revenue to provide incentives for physicians to better manage patient care.

Accountable Care Solutions – Aetna offers consulting services, health information technology solutions, health care analytics and other services to health care providers interested in forming an Accountable Care Organization (ACO). ACOs potentially offer a more systematic and cost effective way of managing the health care needs of a population within specific geographic areas.

Other Aetna initiatives to address medical cost trend:

Ambulatory Surgery Center (ASC) Costs – Aetna is pursuing network and plan design changes designed to reduce non-participating ASC utilization and to encourage non-participating ASCs to join Aetna's provider network.

Emergency Room (ER) Coding: Aetna has identified a trend in which hospitals are billing for emergency room services using codes for patient services that reflect more intense and expensive services. Aetna is aggressively monitoring hospital coding of services rendered in the emergency department. Aetna has also implemented a new claims payment policy designed to prevent up-coding.

Implant Costs: Aetna is monitoring implant costs and enforcing contract provisions requiring audit and overpayment recovery.

Hospital Based Physicians: Aetna is implementing a strategy designed to reduce (non-participating) hospital based physician costs. Strategies include more effective use of cost data and working with hospitals to encourage hospital based physician groups to contract with Aetna.

20. a.: Describe the significant economic, social and medical developments that have been driving Aetna's *in-patient* price inflation in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.

20. b.: Describe the significant economic, social and medical developments that have been driving Aetna's *out-patient* price inflation in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.

There are several important components that drive inpatient and outpatient costs. These include medical costs charged by hospitals, cost shifting by the government, and ongoing market consolidation. We do not expect that inpatient or outpatient price inflation will moderate until the underlying drivers of cost inflation are addressed. Market consolidation is expected to continue and cost shifting by government programs is not likely to change in the near future.

Hospital System Rate Demands: Hospitals have historically faced and continue to be confronted by cost pressures which have caused them to shift costs to commercial payers. Over the last few years and continuing into 2011, systems have demanded increases well into the double digits, with some as high as 60% or more.

Hospitals cite under-funded government programs as the primary reason for the cost shift. Underpayments by Medicare and Medicaid result in a typical insured family paying almost 11% more in premiums. This translates into about $1788 in additional costs per family - $1512 in higher premiums and $276 in higher out of pocket costs. The Kaiser Family Foundation has estimated that the average monthly premium of employer-sponsored family coverage is $1115 per month* so the additional costs that result from cost shifting exceed the amount an average family pays in premiums.

These continual underpayments by public programs make private health insurance significantly more expensive then it otherwise would be.** Medicare only covers 91% of hospital costs. For Medicaid, hospitals received payment of only 88% of every dollar spent by hospitals caring for Medicaid patients.***

Hospitals also point to union labor costs, and costs associated with rebuilding or retrofitting to meet CA seismic regulations as factors contributing to the need for large increases. Over the last two years, other factors associated with the economy have come into play and are used by hospitals as justification for increases. These include:

- Rising number of uninsured patients as well as insured patients who can't pay deductibles/coinsurance (uncollectible debt)
- Increase in patient acuity/deferral of higher margin elective admissions; this means the hospital's cost of care has increased (more acute cases), yet reimbursement levels have not kept pace.
- Losses in investment portfolios and fewer charitable contributions
- Bond rating pressure has increased the cost of capital.

Consolidation - Market consolidation among providers had led to market dominant positions by health systems in both Northern and Southern California. Large health systems can – because of their size and market penetration – demand increases that smaller systems can't. Often the alternatives to not having these providers in the network are far more costly than keeping them in. Provider consolidation is continuing to occur among health care providers in both Northern and

Southern California. Larger and financially stronger hospital systems are acquiring weaker medical groups and hospitals. This has an inflationary effect because the acquiring provider generally commands higher rates. In "Unchecked Provider Clout in California Foreshadows Challenges to Health care Reform" researchers say "evidence from two decades of hospital mergers and acquisitions demonstrates that consolidating hospital markets drives up prices" and they note "a definite shift in negotiating strength toward providers, resulting in higher payment rates and premiums."****

Several items have contributed to this market leverage. There are new provider consolidation and integration strategies where "must have" hospitals and facilities combine with lesser known facilities and then negotiate rates for the entire system in "all or nothing" contracts. Hospitals also are collaborating with doctors and negotiating for the entire system.

An overall physician shortage and reduction in hospital beds as well as consumer demand for broader provider networks also has heightened provider leverage. The enhanced provider market power is demonstrated through the near doubling of California hospital prices from 1999-2005 even though national Medicare hospital inpatient costs per admission increased only 5.5% during the same period.****

One hospital in California is generating charges of 490% of Medicare. Another hospital system has negotiated rates that range from 198% to 316% of Medicare.

Provider consolidation is the most important historical factor in explaining why costs are higher in Northern vs. Southern California. Northern California's health care delivery system is more highly consolidated than in Southern California. Northern California is characterized by the presence of a few large vertically integrated heath systems, including Sutter, Catholic Healthcare West, University of California, and Stanford/Packard in a relatively small geographic area. These health systems employ physicians through their physician foundations.

-Hospital volumes: Stanford 23%; Sutter 20%; the next four largest systems account for 30% of the total market.

-Physician volume: Sutter, Hill, BTMG, SCCIPA, PMG San Jose, and Muir account for 90% of HMO membership

On average, Aetna's normalized per day costs are 43% higher in Northern California than in Southern California and normalized per case costs are 37% (adjusted) higher. Overall, health care prices are 35%-40% higher in Northern California.

<u>Provider Disengagement Contributes to Higher Medical Cost:</u>

Specific California health care providers choose not to contract with Aetna for participation in our provider networks. Non-participating providers contribute to higher health care costs by charging fees, in many cases higher than charges of participating providers, and then billing for these fees on a non-discounted rate basis. As an example of a driver of inpatient service cost inflation, one such provider system, Prime Health, is profiled below.

Prime Heath is a statewide network of hospitals, all of which participated in Aetna's network prior to acquisition by Prime Health but are now non-participating.

Prime Health purchases hospitals and subsequently terminates payer contracts – this affects cost trend during the year in which the termination occurs. Prime Health acquired Alvarado Hospital at the end of 2010 and is expected to continue its acquisition strategy.

- Prime Health purchased its first hospital in 2001. Beginning in 2006, Prime Health began acquiring hospitals in Southern California at a rapid pace. The company now owns fourteen CA hospitals and more acquisitions are expected.

- Prime Health does not contract with commercial insurers, with few exceptions. Upon acquisition of a hospital, Prime Health immediately seeks to terminate all commercial payer contracts. As a result, Aetna and other plans have exposure to billed charges for patients who receive care through Prime Health facilities. On average, Prime hospitals' billed charges are 39% higher than the billed charges of other hospitals in the Southern California market.

Hospital Name	City	County	Beds	Acquisition Date
Alvarado Hospital	National City	San Diego	281	2010-Nov
Centinela Hospital Medical Center	Inglewood	Los Angeles	370	2007-Oct
Chino Valley Medical Center	Chino	San Bernardino	126	2006-Mar
Desert Valley Hospital	Victorville	San Bernardino	183	2001-Jan
Encino Hospital Medical Center	Encino	Los Angeles	151	2008-Jun
Garden Grove Hospital Medical Center	Garden Grove	Orange	167	2008-Jun
Huntington Beach Hospital	Huntington Beach	Orange	131	2006-Sep
La Palma Intercommunity Hospital	La Palma	Orange	141	2006-Sep
Montclair Hospital Medical Center	Montclair	San Bernardino	102	2006-Nov
Paradise Valley Hospital	National City	San Diego	301	2007-Mar
San Dimas Community Hospital	San Dimas	Los Angeles	63	2008-Jun
Shasta Regional Medical Center	Redding	Shasta	246	2008-Dec
Sherman Oaks Community Hospital	Sherman Oaks	Los Angeles	153	2006-Feb
West Anaheim Medical Center	Anaheim	Orange	219	2006-Sep

Further, many hospital based physician groups (emergency room physicians, radiologists, pathologists and anesthesiologists), and a large number of ambulatory surgery centers also choose not to participate in Aetna's network. Many of these hospital based physicians practice at hospitals that participate in health plan contracts. This leads to costly confusion for consumers that receive services at a network hospital only to receive bills from non-participating emergency room physicians, radiologists, pathologists and anesthesiologists. Payments to non-participating surgery centers, many of them owned by the physicians who refer to them, represent an ongoing and significant component of our medical cost.

References:

*Kaiser Family Foundation, Employer Health Benefits 2009
**Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers, December 2008
***American Hospital Association Underpayment by Medicare and Medicaid Fact Sheet, November 2009
****Health Affairs: Unchecked Provider Clout in California Foreshadows, April 2010 http://content.healthaffairs.org/content/29/4/699.abstract

20. c.: Describe the significant economic, social and medical developments that have been driving Aetna members' increasing utilization in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.

Aetna cannot predict the full impact that economic and social developments will have on healthcare utilization for our members, particularly in light of the recent unprecedented economic downturn. The actual social and economic circumstance of each member is not collected or used to determine utilization patterns. Prior year claims experience and trends are the best guides we have of use patterns.

The main drivers of health care utilization for Aetna members mirror those issues facing the larger United States population: chronic disease (obesity, diabetes, congestive heart failure), increasing illness of the aging baby boomer population, end of life care, the impact of premature infant births associated with high risk pregnancy, new drug therapies, and new highly technological procedures and imaging (e.g. spinal surgeries, advances in MRI imaging).

To stem both the cost and utilization of some of these conditions we have initiated multiple local and national initiatives and have collaborated with other public stakeholders. Efforts like our Aetna Compassionate Care Program, and Med-Solutions Precertification programs for high cost technology use, and comprehensive disease management programs are just a sampling of Aetna's programs addressing appropriate use of care.

There may also be geographic factors that influence local utilization patterns of care, such as the higher cost of services in one geographic area versus another and differences in the availability of emergency room or urgent care centers. Efforts to steer members to urgent care centers throughout California rather than use costlier ER settings have been made in collaboration with employers. Transparency tools allowing members to compare the potential cost of services for routine procedures along with robust on-line consumer directed tools are available on Aetna's web site.

Part of our approach to care for our members includes contemporaneous predictions of which members may be at risk for becoming higher users of costly services. We do this during routine case and utilization management, and incorporate known facts of the member's care in our predictions. This approach has allowed us to engage members earlier in plans of care and provide access to care early in the member's illness cycle, thus preventing unnecessary use and costs.

As the economic conditions of many Americans improve and more people return to work, it can be expected that routine use of elective and preventive care will increase. This would be appropriate use of care and should ultimately improve the health of the population. Alternatively, more illness may emerge as those who put off care during the recession present with health care conditions that may be more advanced and thus require more service use and cost. We are prepared to manage this volatility in use, but cannot predict the degree it will rise or fall. Aetna continues to partner with national researchers to determine if improved efforts in coordination of care may be one avenue to improve members' overall health and reduce utilization and health disparities.

References:

1. Aetna Compassionate Care Program http://www.aetna.com/individuals-families-health-insurance/sas/compassionate-care/how-it-works.html
2. Aetna Foundation Supports New Study of Impact of Poorly Coordinated Patient Care http://www.aetna.com/news/newsReleases/2010/1207_AetnaRAND.html

20. d.: Describe whether and how the independent actuary (Milliman) has independently observed these medical trends and whether it includes them in its pricing model.

Milliman reviewed Aetna's historical and projected trends prior to providing an actuarial certification. Aetna's observed and projected medical trends are within the range of trends Milliman has observed for similar products in the same geographical area.

Medical trend assumptions can vary significantly depending on factors unique to each situation. Such factors include type of plan, benefit structure, and geographic area. Moreover, these factors tend to be dynamic, requiring continuous analysis and subjective evaluation. For these reasons, it is difficult to establish a single set of recommended trend factors. Rather, the information in Milliman's pricing model is intended to provide a framework for establishing trend assumptions for a variety of situations.